General

Guideline Title

Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline.

Bibliographic Source(s)

Paice JA, Portenoy R, Lacchetti C, Campbell T, Cheville A, Citron M, Constine LS, Cooper A, Glare P, Keefe F, Koyyalagunta L, Levy M, Miaskowski C, Otis-Green S, Sloan P, Bruera E. Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. J Clin Oncol. 2016 Sep 20;34(27):3325-45. [114 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- August 31, 2016 – Opioid pain and cough medicines combined with benzodiazepines : A U.S. Food and Drug Administration (FDA) review has found that the growing combined used of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. FDA is adding Boxed Warnings to the drug labeling of prescription opioid pain and prescription opioid cough medicines and benzodiazepines.
- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Definitions for the rating of evidence (High, Intermediate, Low, Insufficient); types of recommendations (Evidence based, Formal consensus,

Informal consensus, No recommendation); and strength of recommendations (Strong, Moderate, Weak) are provided at the end of the "Major Recommendations" field.

Clinical Question

How should chronic pain be managed in the adult cancer survivor?

1. Screening and Comprehensive Assessment

Recommendation 1.1

Clinicians should screen for pain at each encounter. Screening should be performed and documented using a quantitative or semiquantitative tool. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: strong)

Recommendation 1.2

Clinicians should conduct an initial comprehensive pain assessment. This assessment should include an in-depth interview that explores the multidimensional nature of the pain (pain descriptors, associated distress, functional impact, and related physical, psychological, social, and spiritual factors) and captures information about cancer treatment history and comorbid conditions, psychosocial and psychiatric history (including substance use), and prior treatments for the pain. The assessment should characterize the pain, clarify its cause, and make inferences about pathophysiology. A physical examination should accompany the history, and diagnostic testing should be performed when warranted. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: moderate)

Recommendation 1.3

Clinicians should be aware of chronic pain syndromes resulting from cancer treatments, the prevalence of these pain syndromes, risk factors for individual patients, and appropriate treatment options. A list of common cancer pain syndromes can be found in Table 3 in the original guideline document. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: moderate)

Recommendation 1.4

Clinicians should evaluate and monitor for recurrent disease, second malignancy, or late-onset treatment effects in any patient who reports new-onset pain. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: moderate)

2. Treatment and Care Options

Recommendation 2.1

Clinicians should aim to enhance comfort, improve function, limit adverse events, and ensure safety in the management of pain in cancer survivors. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: moderate)

Recommendation 2.2

Clinicians should engage patient and family/caregivers in all aspects of pain assessment and management. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: moderate)

Recommendation 2.3

Clinicians should determine the need for other health professionals to provide comprehensive pain management care in patients with complex needs. If deemed necessary, the clinician should deï¬ne who is responsible for each aspect of care and refer patients accordingly. (Informal consensus; beneï¬ts outweigh harms; evidence quality: insuffï¬cient; strength of recommendation: moderate)

Nonpharmacologic Interventions

Recommendation 2.4

Clinicians may prescribe directly or refer patients to other professionals to provide the interventions outlined in Table 4 in the original guideline document to mitigate chronic pain or improve pain-related outcomes in cancer survivors. These interventions must take into consideration pre-existing diagnoses and comorbidities and should include an assessment for adverse events. (Evidence-based; beneï¬ts outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Pharmacologic Interventions: Miscellaneous Analgesics

Recommendation 2.5

Clinicians may prescribe the following systemic nonopioid analgesics and adjuvant analgesics to relieve chronic pain and/or improve function in cancer survivors in whom no contraindications, including serious drug–drug interactions exist:

- Nonsteroidal anti-inflammatory drugs (NSAIDs)
- Acetaminophen (paracetamol)
- Adjuvant analgesics, including selected antidepressants and selected anticonvulsants with evidence of analgesic efficacy (such as the antidepressant duloxetine and the anticonvulsants gabapentin and pregabalin) for neuropathic pain conditions or chronic widespread pain

(Evidence-based; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Recommendation 2.6

Clinicians may prescribe topical analgesics (such as commercially available NSAIDs; local anesthetics; or compounded creams/gels containing baclofen, amitriptyline, and ketamine) for the management of chronic pain. (Evidence-based; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Recommendation 2.7

Corticosteroids are not recommended for long-term use in cancer survivors solely to relieve chronic pain. (Evidence-based; harms outweigh benefits; evidence quality: intermediate; strength of recommendation: moderate)

Recommendation 2.8

Clinicians should assess the risks of adverse effects of pharmacologic therapies, including nonopioids, adjuvant analgesics, and other agents used for pain management. (Evidence-based and informal consensus; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Recommendation 2.9

Clinicians may follow specific state regulations that allow access to medical cannabis or cannabinoids for patients with chronic pain after a consideration of the potential benefits and risks of the available formulations. (Evidence-based; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Pharmacologic Interventions: Opioids

Recommendation 2.10

Clinicians may prescribe a trial of opioids in carefully selected cancer survivors with chronic pain who do not respond to more conservative management and who continue to experience pain-related distress or functional impairment. Tables 5 and 6 in the original guideline document provide guidelines intended to promote safe and effective prescribing. Nonopioid analgesics and/or adjuvants can be added as clinically necessary. (Evidence-based; benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Recommendation 2.11

Clinicians should assess the risks of adverse effects of opioids used for pain management. Table 7 in the original guideline document lists opioid-related long-term adverse effects. (Evidence-based and informal consensus; benefits outweigh harms; evidence quality: intermediate strength of recommendation: moderate)

3. Risk Assessment and Mitigation and Universal Precautions with Opioid Use

Recommendation 3.1

Clinicians should assess the potential risks and benefits when initiating treatment that will incorporate long-term use of opioids. (Informal consensus; benefits outweigh harms; evidence quality: insufficient; strength of recommendation: moderate)

Recommendation 3.2

Clinicians should clearly understand terminology such as tolerance, dependence, abuse, and addiction as it relates to the use of opioids for pain control. (Informal consensus; benefits outweigh harms; evidence quality: insufficient; strength of recommendation: moderate)

Recommendation 3.3

Clinicians should incorporate a universal precautions approach to minimize abuse, addiction, and adverse consequences of opioid use such as opioid-related deaths. Clinicians should be cautious in coprescribing other centrally acting drugs, particularly benzodiazepines (see Table 7 in the original guideline document). (Evidence-based and informal consensus; bene ts outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Recommendation 3.4

Clinicians should understand pertinent laws and regulations regarding the prescribing of controlled substances. (Informal consensus; bene ts outweigh harms; evidence quality: insuf cient; strength of recommendation: moderate)

Recommendation 3.5

Clinicians should educate patients and family members regarding the risks and bene ts of long-term opioid therapy and the safe storage, use, and disposal of controlled substances. Clinicians are encouraged to address possible myths and misconceptions about medication use and should educate patients about the need to be cautious when using alcohol or sedating over-the-counter medications, or in receiving centrally acting medications from other physicians. (Informal consensus; bene ts outweigh harms; evidence quality: insuf cient; strength of recommendation: moderate)

Recommendation 3.6

If opioids are no longer warranted, clinicians should taper the dose to avoid abstinence syndrome. The rate of tapering and the use of cotherapies to reduce adverse effects should be individualized for each patient. (Evidence-based and informal consensus; bene ts outweigh harms; evidence quality: intermediate; strength of recommendation: moderate)

Definitions

Guide for Rating Strength of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
Informal Consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").

Type of Recommendation	Definition
No Recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Chronic pain (cancer or non-cancer-related pain)

Guideline Category

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Oncology

Intended Users

Advanced Practice Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

To provide guidance to clinicians on the effectiveness of treatment options for pain in adults with a history of cancer

Target Population

Any adult who has been diagnosed with cancer and is experiencing pain that lasts ≥3 months, irrespective of cause

Interventions and Practices Considered

Screening/Evaluation/Risk Assessment

1. Screening for pain
2. Comprehensive pain assessment
3. Risks assessment for chronic pain syndromes resulting from cancer treatment
4. Evaluation and monitoring for recurrent disease, second malignancy, or late-onset treatment effects

Treatment/Management

1. Enhancing comfort, improving function, limiting adverse events, and ensuring safety in the management of pain
2. Engaging patients and family/caregivers in all aspects of pain assessment and management
3. Determining need for other health professionals to provide comprehensive pain management care
4. Nonpharmacologic interventions
5. Pharmacologic interventions
    - Nonsteroidal anti-inflammatory drugs (NSAIDs)
    - Acetaminophen (paracetamol)
    - Adjuvant analgesics, including selected antidepressants and selected anticonvulsants with evidence of analgesic efficacy
    - Topical analgesics
    - Corticosteroids (not recommended for long-term use)
    - Cannabis/cannabinoids according to state law
    - Opioids
6. Assessing risks of adverse effects of pharmacologic therapies
7. Risk assessment and mitigation and universal precautions with opioid use

Major Outcomes Considered

- Symptom relief
- Patient-reported pain intensity (pain rating scale)
- Participant-reported global impression of clinical change
- Quality of life (measured by a validated, reliable instrument [e.g., the Functional Assessment of Cancer Therapy–Endocrine Symptoms and the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire])
- Disability measure

- Pain interference
- Functional outcomes
- Caregiver end points such as distress or decision burden
- Adverse events, including misuse or diversion
- Barriers
- Risk assessment or mitigation

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Literature Search Strategy

PubMed library was searched for evidence reporting on outcomes of interest. Further details on the search strategy and results are provided in Data Supplements 2 and 3 (see the "Availability of Companion Documents" field).

Articles were selected for inclusion in the systematic review of the evidence if they:

- Included adult cancer survivors at risk of or with chronic pain, although literature on chronic pain in other adult populations was also considered because of the paucity of evidence in cancer survivors
- Considered either cancer pain or noncancer pain
- Investigated the efficacy or harms of pharmacologic or nonpharmacologic interventions for pain management
- Reported results on any of the following outcomes: symptom relief; patient-reported pain intensity (pain rating scale); participant-reported global impression of clinical change; quality of life (measured by a validated, reliable instrument (e.g., the Functional Assessment of Cancer Therapy–Endocrine Symptoms and the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire); disability measure; pain interference; functional outcomes; caregiver end points such as distress or decision burden; adverse events, including misuse or diversion; barriers; or risk assessment or mitigation
- Were fully published, English-language reports of systematic reviews, meta-analyses, randomized controlled trials (RCTs), or comparative observational studies

Articles that considered acute pain were not included. Studies were also excluded from the systematic review if they were meeting abstracts that were not published subsequently in peer-reviewed journals, or were editorials, commentaries, letters, news articles, case reports, or narrative reviews.

Number of Source Documents

A total of 35 systematic reviews, nine randomized controlled trials (RCTs), and 19 comparative studies met the eligibility criteria and form the evidentiary basis for the guideline recommendations. Two existing clinical practice guidelines were also identified to help inform the discontinuation of long-term opioid therapy.

See Data Supplement 3 (see the "Availability of Companion Documents" field) for a Quality of Reporting of Meta-analyses (QUOROM) Diagram showing exclusions and inclusions of publications identified for the systematic review.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Guide for Rating Strength of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Rating of Potential for Bias

Rating of Potential for Bias	Definitions for Rating Potential for Risk of Bias in Randomized Controlled Trials
Low risk	No major features in the study that risk biased results, and none of the limitations are thought to decrease the validity of the conclusions. The study avoids problems such as failure to apply true randomization, selection of a population unrepresentative of the target patients, high dropout rates, and no intention-to-treat analysis; and key study features are described clearly (including the population, setting, interventions, comparison groups, measurement of outcomes, and reasons for dropouts).
Intermediate	The study is susceptible to some bias, but flaws are not sufficient to invalidate the results. Enough of the items introduce some uncertainty about the validity of the conclusions. The study does not meet all the criteria required for a rating of good quality, but no flaw is likely to cause major bias. The study may be missing information, making it difficult to assess limitations and potential problems.
High risk	There are significant flaws that imply biases of various types that may invalidate the results. Several of the items introduce serious uncertainty about the validity of the conclusions. The study has serious errors in design, analysis, or reporting; large amounts of missing information; or discrepancies in reporting.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction

Literature search results were reviewed and deemed appropriate for full text review by two American Society of Clinical Oncology (ASCO) staff reviewers in consultation with the Expert Panel Co-Chairs. Data were extracted by two staff reviewers and subsequently checked for accuracy through an audit of the data by another ASCO staff member. Disagreements were resolved through discussion and consultation with the Co-Chairs if necessary. Evidence tables are provided in the original guideline document and/or in Data Supplements 1 and 2 (see the "Availability of Companion Documents" field).

Study Quality Assessment

An assessment of study quality was performed for all the included evidence by one methodologist. Systematic reviews and meta- analyses were assessed for quality using A Measurement Tool to Assess Systematic Reviews (AMSTAR).

Design elements such as blinding, allocation concealment, placebo control, intention to treat, funding sources, and so forth, were assessed for randomized controlled trials (RCTs). Methodologic criteria assessed for other study designs included type of data collection, sampling method, and conflicts of interest. In general, most of the identified studies exhibited a low to intermediate potential risk of bias. AMSTAR scores ranged from 3 to 11 out of a possible 11 points. Overall, the included systematic reviews were conducted in a rigorous fashion; however, many of the primary studies included in these reviews, and other primary RCTs identified for inclusion in this analysis, suffered from industry sponsorship, short follow-up, lack of blinding, and lack of reporting of intention-to-treat analyses. Moreover, outcomes varied greatly across studies and were often assessed by different methods or measurement scales. Refer to the Data Supplement (see the "Availability of Companion Documents" field) for ratings of overall potential risk of bias.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Panel Composition

The American Society of Clinical Oncology (ASCO) Clinical Practice Guidelines Committee (CPGC) convened an Expert Panel with multidisciplinary representation in medical oncology, radiation oncology, cardiology, exercise physiology, family medicine, cancer prevention, cancer survivorship, patient/advocacy representation, and guideline implementation. The Expert Panel was led by three Co-Chairs who had primary responsibility for the development and timely completion of the guideline. For this guideline product, the Co-Chairs selected additional members from the Update Committee to form a Writing Group/Steering Committee to assist in the development and review of the guideline drafts.

Guideline Development Process

The expert panel met in person and via teleconference and corresponded through e-mail. On the basis of the consideration of the evidence, the authors were asked to contribute to the development of the guideline, to provide critical review, and to finalize the guideline recommendations. Members of the expert panel were responsible for reviewing and approving the penultimate version of the guideline.

The recommendations were developed by an expert panel with multidisciplinary representation, who used a systematic review (1996 to 2015) of randomized controlled trials (RCTs), observational studies, and clinical experience. In some selected cases in which evidence was lacking, but where there was a high level of agreement among the members of the panel and where the benefits clearly outweighed the harms, informal consensus was used (as noted in the "Major Recommendations" field).

The guideline recommendations are crafted, in part, using the GuideLines Into Decision Support (GLIDES) methodology. In addition, a guideline implementability review was conducted. On the basis of the implementability review, revisions were made to the draft to clarify recommended actions for clinical practice. Ratings for the type and strength of recommendation, evidence, and potential bias are provided with each recommendation.

Rating Scheme for the Strength of the Recommendations

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
Informal	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The

Type of Recommendation	Definition
Consensus	recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Members of the expert panel were responsible for reviewing and approving the penultimate version of the guideline, which was then circulated for external review and submitted to *Journal of Clinical Oncology* for editorial review and consideration for publication. All American Society of Clinical Oncology (ASCO) guidelines are ultimately reviewed and approved by the expert panel and the ASCO Clinical Practice Guideline Committee (CPGC) prior to publication.

The CPGC approved this guideline on April 18, 2016.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Provision of a multimodality plan of care that balances pharmacologic and nonpharmacologic techniques with a focus on improving function and limiting the long-term adverse effects of pain and of its treatment and improving comfort

Refer to the "Literature review, analysis, and clinical interpretation" sections of the original guideline document for a detailed discussion of the potential benefits and harms of each recommendation.

Potential Harms

- Risks of adverse effects of pharmacologic therapies
- Drug–drug interactions with cancer therapies or other treatments
- Adverse effects of opioids used (Table 7 in the original guideline documents lists opioid-related long-term adverse effects, which include constipation, mental clouding, upper gastrointestinal symptoms, endocrinopathies, neurotoxicity, and sleep-disordered breathing)
- Abuse, addiction, and adverse consequences of opioid use such as opioid-related deaths

Refer to the "Literature review, analysis, and clinical interpretation" sections of the original guideline document for a detailed discussion of the potential benefits and harms of each recommendation.

Qualifying Statements

Qualifying Statements

- The clinical practice guidelines and other guidance published herein are provided by American Society of Clinical Oncology (ASCO) to assist providers in clinical decision making. The information herein should not be relied on as being complete or accurate, nor should it be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. With the rapid development of scientific knowledge, new evidence may emerge between the time information is developed and when it is published or read. The information is not continually updated and may not reflect the most recent evidence. The information addresses only the topics specifically identified therein and is not applicable to other interventions, diseases, or stages of diseases. This information does not mandate any particular course of medical care. Furthermore, the information is not intended to substitute for the independent professional judgment of the treating provider, because the information does not account for individual variation among patients. Recommendations reflect high, moderate, or low confidence that the recommendation reflects the net effect of a given course of action. The use of such words as "must," "must not," "should," and "should not" indicates that a course of action is recommended or not recommended for either most or many patients, but there is latitude for the treating physician to select other courses of action in individual cases. In all cases, the selected course of action should be considered by the treating provider in the context of treating the individual patient. Use of the information is voluntary. ASCO provides this information on an as is basis and makes no warranty, express or implied, regarding the information. ASCO specifically disclaims any warranties of merchantability or fitness for a particular use or purpose. ASCO assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this information, or for any errors or omissions.
- See the "Health Disparities," "Multiple Chronic Conditions" and "Limitation of the Research" sections in the original guideline document for additional qualifying information.
- See the original guideline document for qualifying statements related to each recommendation.

Implementation of the Guideline

Description of Implementation Strategy

Guideline Implementation

American Society of Clinical Oncology (ASCO) guidelines are developed for implementation across health care settings. Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and survivors of cancer and their caregivers and to provide adequate services in the face of limited resources. The guideline Bottom Line Box was designed to facilitate implementation of recommendations. This guideline will be distributed widely through the ASCO Practice Guideline Implementation Network. ASCO guidelines are posted on the ASCO Web site and most often published in *Journal of Clinical Oncology (JCO)* and *Journal of Oncology Practice*.

For additional information on the ASCO implementation strategy, please see the ASCO Web site.

Implementation Tools

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Paice JA, Portenoy R, Lacchetti C, Campbell T, Cheville A, Citron M, Constine LS, Cooper A, Glare P, Keefe F, Koyyalagunta L, Levy M, Miaskowski C, Otis-Green S, Sloan P, Bruera E. Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. J Clin Oncol. 2016 Sep 20;34(27):3325-45. [114 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2016 Sep 20

Guideline Developer(s)

American Society of Clinical Oncology - Medical Specialty Society

Source(s) of Funding

American Society of Clinical Oncology (ASCO)

Guideline Committee

Management of Chronic Pain in Adult Cancer Survivors Expert Panel

Composition of Group That Authored the Guideline

Expert Panel Members: Judith A. Paice, PhD/RN (*Co-chair*), Northwestern University Feinberg School of Medicine; Michael Levy, MD, PhD (*Co-chair*), Fox Chase Cancer Center; Eduardo Bruera, MD (*Co-chair*), MD Anderson Cancer Center; Toby Campbell, MD, University of Wisconsin-Madison; Louis S. Constine, MD, University of Rochester Medical Center; Shirley Otis-Green, MSW, Coalition for Compassionate Care of California; Christine Miaskowski, RN, PhD, University of California San Francisco; Andrea Cheville, MD, Mayo Clinic; Paul Glare, MD, University of Sydney; Frank Keefe, PhD, Duke University; Lakshmi Koyyalagunta, MD, MD Anderson Cancer Center; Paul Sloan, MD, University of Kentucky; Marc Citron, MD (*Practice Guideline Implementation Network [PGIN] representative*), ProHealth Care Assoc; Russell Portenoy, MD, Metropolitan Jewish Health System Institute for Innovation in Palliative Care; Andrea Cooper, patient representative; Christina Lacchetti, American Society of Clinical Oncology (ASCO) staff

Financial Disclosures/Conflicts of Interest

The Expert Panel was assembled in accordance with the American Society of Clinical Oncology's (ASCO's) Conflict of Interest Policy Implementation for Clinical Practice Guidelines (Procedures, summarized at www.asco.org/rwc). Members of the panel completed ASCO's disclosure form, which requires disclosure of financial and other interests that are relevant to the subject matter of the guideline, including relationships with commercial entities that are reasonably likely to experience a direct regulatory or commercial impact as a result of promulgation of the guideline. Categories for disclosure include employment; leadership; stock or other ownership; honoraria; consulting or advisory role; speakers' bureau; research funding; patents, royalties, other intellectual property; expert testimony; travel, accommodations, expenses; and other relationships. In accordance with the procedures, the majority of the members of the Panel did not disclose any such relationships.

Authors' Disclosures of Potential Conflicts of Interest

The following represents disclosure information provided by authors of the guideline. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to www.asco.org/rwc or jco.ascopubs.org/site/ifc .

Judith A. Paice
No relationship to disclose

Russell Portenoy
Research Funding: Pfizer (Inst)

Christina Lacchetti
No relationship to disclose

Toby Campbell
No relationship to disclose

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No relationship to disclose

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No relationship to disclose

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Patents, Royalties, Other Intellectual Property: My son, Varun Koyyalagunta, has a patent pending (I)

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No relationship to disclose

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No relationship to disclose

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No relationship to disclose

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No relationship to disclose

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No relationship to disclose

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Journal of Clinical Oncology Web site .

Availability of Companion Documents

The following are available:

- Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. Methodology supplement. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2016. 12 p. Available from the Journal of Clinical Oncology Web site.
- Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. Data supplements 1-3. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2016. 30 p. Available from the Journal of Clinical Oncology Web site.
- Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. Slide set. Alexandria (VA): American Society of Clinical Oncology; 2016. 23 p. Available in PDF and PowerPoint from the American Society of Clinical Oncology (ASCO) Web site.
- Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. Summary of recommendations table. Alexandria (VA): American Society of Clinical Oncology; 2016. 5 p. Available from the ASCO Web site.
- Paice JA, Lacchetti C, Bruera E. Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline summary. J Oncol Pract. 2016 Aug;12(8):757-62. Available from the Journal of Oncology Practice.
- Universal precautions in chronic cancer pain management. Flow chart. Alexandria (VA): American Society of Clinical Oncology; 2016. 1 p. Available from the ASCO Web site.
- Opioid risk stratification and adherence monitoring. Flow chart. Alexandria (VA): American Society of Clinical Oncology; 2016. 1 p. Available from the ASCO Web site.

Patient Resources

A variety of patient resources about pain are available from the Cancer.Net Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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